Wyoming Health
Medical Group LLC
Wyoming Medical Center

CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____, born the _____ day of _____, 20____ do hereby consent to any medical care determined by a provider to be necessary for the welfare of my child while said child is under the care of _____ of _____, City of _____ State of _____.

This authorization is effective from the ___ day of _____, 20____ to

_____ day of _____, 20____.

_____ _____

Signature of Parent or Legal Guardian **Date**

_____ _____

Witness Signature **Witness Name (please print)**

This consent form should be returned to and/or taken with the child to the provider's office when the child is taken for treatment.

Additional information requested that will assist in treatment. This is not required.

Family Address _____

Parent or Legal Guardian's Telephone Number: _____

Allergies to drugs or foods: _____

Special Medications or Other Information to assist in care: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____